A D H S / D B H S

ARIZONA INTEGRATED TREATMENT CONSENSUS PANEL

A Collaborative Project of the ADHS/DBHS Bureau for Adult Services
and the Bureau of Substance Abuse Treatment & Preventions Services

Fall 2002 Issue 5

Where do I get more information?

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How To Get Involved?

Each of the regional behavioral health geographic areas now have Local Consensus Panels actively meeting to plan the implementation of integrated treatment in their respective geographic areas. For more information on activities in each of these areas, contact the following:

Value Options
Eric Raider 1-800-564-5465

CPSA
Cheryl Fanning/Angela Guide
520-325-4268

NARBHA
Bob Perrone/Samantha Schiess
(520)774-2070

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EXCEL
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ARIZONA INTEGRATED TREATMENT CONSENSUS PANEL ADOPTS SERVICE PLANNING GUIDELINES FOR CO-OCURRUING PSYCHIATRIC AND SUBSTANCE DISORDER

The Arizona Integrated Treatment Consensus Panel has adopted the service planning guidelines developed by Dr. Kenneth Mincoff in February of 2002. These guidelines are based on data collected from evidence-based and consensus-based best practices. Although more study is needed, the guidelines can be used for assessment, treatment, and psychopharmacology of individuals with co-occurring disorders. The guidelines can be downloaded at www.hs.state.az.us/bhs/tx_co_occur.

The guidelines are also based upon the following principles developed by the Arizona Integrated Treatment Consensus Panel in 1999:

1. **Integrated Assessment, Treatment and Recovery** – Psychiatric and substance disorders, regardless of severity, tend to be persistent and recurrent, and these disorders co-occur with sufficient frequency and complicate each other so that a continuous and integrated approach to assessment, treatment and recovery is required. Regardless of the location of initial and subsequent clinical presentations, integrated services should be available to anyone who would benefit. Assessments must be inclusive of both disorders and must include understanding the individual in the context of their home, community, etc.

2. **Use of Existing Services and Programs** – A comprehensive integrated service system should be created by building on the strengths of the current system, services and programs to incorporate the principles and model of integration. When needed, new services and programs will be developed. New services and programs will be evidence based and/or will be innovations that have a high likelihood of success.

3. **Continuity of Care** – The comprehensive integrated service system will provide early access to continuous integrated treatment relationships which can be maintained over time, through multiple episodes of acute and sub-acute treatment and follow-up care. Maintaining these relationships is independent of any particular treatment setting.

4. **Dual Primary Treatment** – The recommended treatment approach is integrated dual primary treatment, in which:
   a. Each disorder receives specific and appropriately intensive integrated primary treatment that takes into account the level of severity and engagement for each disorder, and any complications resulting from the co-occurring disorders.

Continued on page 5

Arizona Integrated Treatment Consensus Panel (AITCP) Commitment Continues in 2003

At the March 22, 2002 AITCP meeting there was a lengthy discussion regarding what is the future direction of the AITCP and what will happen when the Community Action Implementation Grant ends.

In a letter to the panel members, Michael Shafer emphasized the continued commitment to this project, "As we all agreed that this important initiative needs to continue, the Arizona Department of Health Services, Division of Behavioral Health (ADHS) and the University of Arizona, Community Rehabilitation Division (U of A/CRD), through the SAMSHA funded Arizona Practice Improvement Collaborative will provide facilitation and funding for twice yearly meetings of the Statewide Advisory Panel." In addition, an extension of the federal funding has been granted until March of 2003.

""As we all agreed that this important initiative needs to continue, the Arizona Department of Health Services, Division of Behavioral Health (ADHS/DBHS) and the University of Arizona, Community Rehabilitation Division (U of A/CRD), through the SAMSHA funded Arizona Practice Improvement Collaborative will provide facilitation and funding for twice yearly meetings of the Statewide Advisory Panel."

At the upcoming meeting, each local panel will be identifying three priorities for the next year. The local panels will also provide plans on how they will address each of the their priority areas. Information on the assistance needed to accomplish each priority area (i.e. policy change, funding, etc.) will be collected. Each panel will also identify anticipated outcomes associated with addressing the three priority areas.

The AITCP members are committed to sustaining and institutionalizing the change that is underway to improve service delivery for individuals with co-occurring disorders.

Key Component of the 2000 IQE on Focused on Individuals with Co-occurring Disorders

Each year ADHS/DBHS completes an Independent Quality Evaluation. The 2000 IQE included evaluation of services for individuals with and without co-occurring disorders.

The Health Services Advisory Group, Inc. (HSAG) collaborated with Dr. Kenneth Minkoff to develop the tool used in the evaluation. The tool was based on Service Planning Guidelines for Co-occurring Psychiatric and Substance Disorders.

The study examined the quality, appropriateness and outcomes of the behavioral health services provided to 1,680 individuals in the review.

Positive findings included clinical outcomes related to symptom stability and prevention of adverse events, no evidence of differences in performance based on funding source or age, appropriate psychopharmacology and no evidence of diagnostic discrimination or discontinuation of treatment based on co-morbid substance abuse.

The opportunities for improvement included improved documentation, assessment and management of co-occurring substance use disorders, increase the utilization of collateral information and better coordination with primary care physicians.

This review provided an excellent baseline and guidance for future evaluations.

Provider Survey Conducted

A survey was conducted to give a point in time baseline against which to measure the progress in integrating services. Approximately 116 agencies were sent an advance letter describing the interview, and were contacted by telephone between September 21, 2001 and November 20, 2001 to conduct an interview. Calls to the agencies revealed that 40 of them did not provide mental health or substance abuse treatment services to adults. Of the remaining 76 agencies, 60 completed the interview for a response rate of 79%. Of the remaining 16 agencies, nine refused to complete the interview, and seven were unavailable to complete the survey after repeated contacts. Survey findings include:

- Of the 60 agencies surveyed, 78.3 (47 agencies) are licensed as both mental health and substance abuse treatment providers.
- Of that 78.3% (47 agencies) that are licensed as both mental health and substance abuse treatment providers, 40% (24 agencies) provide formal co-occurring treatment services and 38.3% (23 agencies) have no formal co-occurring treatment services.
- Of the 24 agencies that provide formal co-occurring treatment services indicators of institutionalization including use of ASAM criteria, provision medication and forma evaluation.

The survey will be re-administered in the future.

Local Panel Updates

CPSA

Angela Guida, Co-Chair, CPSA Local Advisory Panel on Integrated Treatment, reports that steady progress continues to occur in the CPSA service areas. The Local Advisory Panel (The Big Group) has been meeting quarterly over the past year and has put the finishing touches on their three program priorities for the coming year. These priorities will be presented at the next statewide meeting.

Subcommittees of the Big Group have also been meeting during the year to address particular issues or needs. For example, the Training Task Force planned and implemented two separate days of training for CPSA stakeholders. One training workshop was targeted to provider agency CEO's, Medical Directors, Quality Management staff and Supervisors. The focus of this training by Dr. David MeeLee was on the planning, evaluation, administration and decision making tasks crucial to implementing and supporting integrated treatment.

Another "training day" focused on ASAM criteria and standards for integrated treatment. This well-received workshop, featuring nationally known expert Dr. David Mee-Lee, was conducted in March. The workshop was presented in Sierra Vista and was targeted for clinicians, consumers, and other integrated treatment stakeholders who work and live in the rural communities of Southern Arizona. Angela reports that there was a great turnout for the ASAM training and that CPSA stakeholders continually express the desire for more training opportunities related to services for persons with co-occurring disorders.

Angela reports that the Local Advisory Panel has been on a well-deserved "summer hiatus" but are now gearing up for the September quarterly meeting. At this meeting, a task force and subcommittees will be formed to address the three program priorities that have been developed for the coming year.

The EXCEL Group

The EXCEL Group meeting for the local integrated consensus panel is the second Monday of the month. Group members have determined that the meeting should be held at 5:30pm. The consensus was that more participants would be likely to attend if the meeting was held at this time instead of later as it had been scheduled previously. Meeting times are posted and the local panel members continue to solicit membership from providers, consumers, and EXCEL staff.

The local panel has prioritized the following:

- Educating current staff regarding the need for and benefits of integrated treatment for person's with co-occurring disorders.
- Recommend training be provided by prominent treatment advocates to increase community support.
- Continue to advocate for a local medical detox facility and more community activities for adolescents with co-occurring disorders.

The next meeting will be held on August 12 at 5:30pm.

NARBHA

The Northern Arizona Regional ITP has been in existence for 2 years. The mission of this regional committee has been the development and implementation of a comprehensive, integrative and effective system of community based care for consumers of behavioral health treatment services with co-occurring disorders of mental illness and substance use/abuse who reside in northern Arizona.

Another exciting development is the rollout of the Train the Trainers that is focusing on increasing both sensitivity to the needs of those suffering from two major disorders and developing staff competency. One of the concepts is Motivational Interviewing. The Panel is also looking forward to Dr. MeeLee presenting a training in the near future in Flagstaff.

PGBHA

The Local Co-Occurring Panel has been reformed and met on Wednesday, June 26, 2002. Members include: Romualdo Munoz, PGBHA, Director of Program Development and Support, Dr. Michael Stumpf, PGBHA, Medical Director, Kevin Hoy, PGBHA, Correctional Officer/ Offender Liaison, Russell Smith, PGBHA, Program Development Coordinator - SMI Population, Michael Munion, SMMHC, Clinical Director
Teresa Menchaca, Pinal Hispanic, Clinical Director and Melissa Knight, Pinal County Adult Probation.

They are developing a plan for the use of funding from the state Substance Abuse Treatment and Prevention block grant. We are focusing on the development of an Intensive Wrap Around Pilot Program targeted on substance abusing families. Additionally, PGBHA has partnered with Pinal County Adult Probation in pursuing a SAMHSA grant on jail diversion.

ValueOptions

The Local Consensus Panel has developed program standards. The panel considered the integrated treatment principles, the service planning guidelines and the ASAM criteria in

Continued on page 4

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Continued from page 1

b. Each individual has a primary treatment relationship with an individual who coordinates ongoing treatment interventions for all co-occurring disorders.

c. Each individual receives treatment for co-occurring disorders in the setting or service system that is most appropriate to the needs of the individual.

5. **Empathic Relationship** – The single most important factor for recovery from co-occurring illnesses is an empathic service relationship in which the individual experiences the hope of dual recovery and is considered to have the potential to achieve dual recovery.

6. **Recovery Model** – The recovery model as used herein, includes harm reduction and disease management models as well as recovery models. Disease management and recovery models are used for conceptualizing assessment and treatment for both disorders. For purposes of this document, recovery is defined as a process by which an individual with a persistent, possibly disabling disorder, recovers self-esteem, self-worth, pride, and dignity and meaning through acquiring increasing ability to maintain stabilization of the disorders, by developing symptom management skills, and the capacity to maximize functioning within the constraints of the disorder.

7. **Developmental Model** – Persons with co-occurring disorders need a judicious combination of supportive case management and care to stabilize symptoms, and empathic detachment and empowerment to promote recovery and self-sufficiency.

8. **Co-Occurring Medication and Substance Use** – It is imperative that persons with mental health and substance abuse co-occurring disorders are provided access to effective medications for both disorders. For example, the presence of substance use, abuse, or dependence does not preclude the provision of psychotropic medications.

9. **Unconditional Commitment** - There will be a long term, unconditional commitment to the individual. Expectations will be realistic and individuals will be provided a welcoming environment initially and at all times thereafter.

10. **Cultural Competency** – The system will provide culturally relevant care that addresses and respects language, customs, values and mores and will have the capacity to respond to the individual's unique family, culture, traditions, and strengths.

11. **Effectiveness** – The services will be outcome based as defined by the consumer and will provide evidence of effectiveness through the appropriate use of periodic outcome evaluations and consumer satisfaction assessments.

These guidelines are very extensive and include practice standards, principles for assessment (screening, detection and diagnosis), treatment interventions, program types and psychopharmacology practice guidelines. The document is over 24 pages and also provides a symptomatolgy table for substance use and psychiatric symptoms.

Training Modules on Co-Occurring Disorders Now Available!

A key objective of the AITCP focused on improving the skills and competencies of direct staff across the state. Six (6) core competency modules are in development and four modules have been completed. The content of these modules is based on the critical competencies previously identified by the Competencies Enhancement Workgroup of the Phase I Consensus Panel (this document is available at www.hs.state.az.us/bhs/finalplan.)

The Community Rehabilitation Division serves as production coordinator for the development of these modules. Each module was assigned to one or more technical writers and identified clinical experts in the areas specified by the module. Each module is designed as an "off-the-shelf" training resource that RBHA training personnel, treatment agency personnel and others could use to enhance their staff's knowledge and competencies in working with individuals displaying co-occurring disorders. Accordingly, each completed module includes at a minimum, PowerPoint slide-show presentations, speaker's notes, participant handouts and readings, as well as learner assessment tools, group exercises, and homework/fieldwork reinforcement activities.
Upon completion of each module, a "Train the Trainers" Workshop is scheduled to present the modules to RBHA training personnel and treatment agency training personnel to assist in "fine tuning" their use for specific training activities. A "Train the Trainers" workshop took place in Tucson, AZ on February 26, 2002 to present the above referenced training module to RBHA and treatment agency staff. To maximize the effectiveness of the training modules rolled out thus far, Michael S. Shafer, Ph.D., provided the presentation "Effective Training of Adult Professionals". The 24 participating behavioral health professionals earned a total of 114 hours of continuing education credits at this workshop.

For questions or additional information on the training modules, please contact Marvin Ruth at 800-724-2855.

Modules Currently Available

Dual Diagnosis – Epidemiology and Assessment/ Integrated Treatment 101: How to Recognize Co-Occurring Mental Illness and Substance Abuse Disorders
Featuring: Kim Mueser, Ph.D., Patricia Penn, Ph.D. and four consumer interviews.

Dual Diagnosis – Integrated Treatment: How Do We Do It?
Featuring: Kim Mueser, Ph.D., Patricia Penn, Ph.D. and three consumer interviews

Five Module Series on Motivational-Based Treatment Strategies for Persons with Co-Occurring Disorders:

Motivational Interviewing
- Module 1: Models of Motivation
- Module 2: Continuum of Change
- Module 3: Responding to Resistance
- Module 4: Developing Discrepancy
- Module 5: Accessing Assessment

Featuring: Robert Rhode, Ph.D.

Integrated Treatment 201: Medications and Integrated Treatment
Featuring: Phillip Kanof, M.D., Ph.D., Martha Fankhauser, M.S. Pharm., Sarah Elmarhoumi, Pharm.D., Andrea Bellot, Pharm.D. and a consumer interview

Local Panel Updates-continued from page 3

developing the standards. The local panel put the principles into person-centered language. The local panel reviewed the assessment tools the URICA and the UNCOPE document they are being piloted at the clinics with excellent results. The local panel also created a draft document on stages of change and defining intervention and strategies. This document will be used as an assessment of what stage of change the person is in currently.

The Minkoff's Guidelines were broken out into Principles. Those Principles were then used to create the second survey and interview questions for the site visits. The Continuum of Care Committee sent out the new surveys starting in May 2002. When they receive the responses two of the committee members will be setting up times to interview the providers that responded in order to provide technical assistance. This will be done with the intention of developing or expanding existing co-occurring services at their agency. While the panel members are at the providers the will be determine if the standards of "welcoming" are being used and if further training is required (see above).

The local panel has developed a Clinical Guidance Committee for Co-occurring Disorders. They will provide Technical Assistance to clinicians that are dealing with difficult cases. The panel will be made up of culturally diverse and multidisciplinary members. The local panel believes that this committee is a place where professionals can come for assistance with challenging cases and system specific issues.

The local panel continues to actively recruit new members. The panel meets on the third Tuesday of the month at 10 am at ValueOptions in the fourth floor conference room. Any one wishing to attend can contact Eric Raider at ValueOptions at 602-914-5800.